Final Investigative Report to the US District Court
December 3, 2012
Matter Involving Student MD on November 27, 2012

On Tuesday, November 27, 2012, at approximately 2:15pm, Chief of Bus Operations, Ms. Patrice Bowman, notified me that a student had been on a bus since approximately 7:35 am that morning when he was picked up at his home, until he was found later that afternoon on the bus at Southwest Terminal at approximately 2:00 pm. Based on this information, we immediately took steps to secure the well-being of the student, who appeared to be in good condition. After further medical evaluation as described below, the student was assessed to be in good condition. Immediate action was taken to terminate the driver and the attendant. Below is OSSE DOT's final report regarding the November 27, 2012 incident.

A Failure to Adhere to Uniform Protocols

The investigation confirms that both the bus driver and attendant failed to follow established procedures and protocols they had been trained to perform; and that any one of the protocols, would have prevented this situation from occurring. The driver and/or the attendant statements dated November 27, 2012, confirm the following:

- Failure of the bus attendant to sit in the appropriate seat on the bus (behind all students so all students are in view);
- Failure of both the bus driver and attendant to check the bus for students after school drop off before departing from the school;
- Failure of both the bus driver and attendant to check the bus upon return to the terminal following completion of the morning run to the school; and
- Failure of the bus driver to use the safety alert buzzer on the bus, which activates

whenever the ignition is turned off, and requires one to walk from the front of the vehicle to the back of the bus to turn off the buzzer.

OSSE DOT Corrective Actions Have Been Taken

Immediately following the incident, OSSE DOT took the following actions to remind all DOT employees of the critical importance of these and other protocols affecting the safety and well being of the students with disabilities transported in their care. As noted above OSSE DOT has in place appropriate policies and procedures specifically targeting situations to prevent incidents where a student is left on a bus during the daily transportation to and from school. Immediately following this incident, OSSE DOT sent out a notification to employees reminding them of the importance of compliance. OSSE DOT has:

- Reinforced the critical importance for adhering to established policies and protocols which will prevent this type of incident from occurring (*See* attached memo distributed to all OSSE DOT staff).
- Scheduled refresher training for the week of December 3, 2012, regarding proper unloading of students and pre and post trip inspection procedures.

Narrative Summary of Incident

The following is a summary of the investigation, my conclusions and actions taken. On Tuesday, November 27, 2012, bus number 4081 departed from 4 DC Village Lane SW, (Southwest Bus Terminal) on route 307. The bus departed the terminal on time at approximately 6:55 am en route to pick up students and take them to Walker Jones

Elementary School, a District of Columbia Public School. The bus arrived at MD's home at approximately 7:35 am for a regularly scheduled pick up. Key facts include:

- Bus driver: JR; 10 years of experience with DOT
- Bus attendant: QG, 6 years of experience with DOT
- Bus number: 4081
- Route number: 307
- Total students scheduled on the route: 8 (6 students rode the bus on Tuesday, November 27, 2012)
- Attending school: DCPS Walker Jones Elementary School, 1125 New Jersey Ave NW 20001 Washington DC
- Student involved: MD, 3 years, 11 months old

At approximately 8:20 am, bus number 4081 arrived at Walker Jones for the regularly scheduled drop off of students. The bus aide at the school came to the bus to assist in unloading the students. During this time, the bus driver (JR) completed required paperwork which he signed as true and complete. The bus attendant (QG) did not leave the bus when it arrived at the school. The DCPS bus aide met the students at the bus assisting them into the school. Bus 4081 departed Walker Jones at approximately 8:30 am and returned to Southwest Terminal at approximately 8:52 am, with the student still on the bus. A bus monitor reported that she boarded the bus when it returned to the bus terminal that morning, shortly before 9 am. She stated that she spoke to the driver, and proceeded to the middle of the bus where the attendant was seated. She then left the bus, stating she was not required to walk to the back of the bus. She stated she received a call from another employee

several hours after she had left the terminal, and that upon hearing about the incident, was "totally surprised" because she only saw two people on the bus – the bus driver and the attendant.

Upon returning to the terminal and parking the bus, JR has stated he completed a required post-trip inspection for the exterior of the bus but did not complete the required post-trip inspection for the bus's interior. The post-trip inspection form indicates that JR "checked for persons". QG has stated that she left the bus and did not assist with the post-trip inspection as required. JR and QG each admitted in separate statements on November 27, 2012, that they did not check the bus for students as required.

At approximately 2:00 pm, JR and QG clocked in at the terminal in preparation for their afternoon route. QG reported that at approximately 2:05pm, she boarded bus 4081 and at that time noticed MD sitting in his booster seat on the bus. QG notified JR and terminal management, who immediately removed MD from the bus and contacted Emergency Medical Services (EMS) and Metropolitan Police. Additionally, terminal management staff notified the Chief of Bus Operations, Ms. Patrice Bowman, and me. At approximately 2:35pm, I notified MD's mother, Ms. D. I provided Ms. D with a status of the incident and put her in touch with the EMS personnel at the terminal. When I spoke with Ms. D, her immediate reaction was that MD must "have fallen asleep."

EMS personnel conferred with Ms. D. Ms. D requested that EMS personnel take extra precautions and transport MD to Georgetown University Hospital and that she would meet them at that location. MD's regular pediatrician works out of Georgetown Hospital. Upon notification of this development, the State Superintendent of Education – Dr. Mahaley-

Jones – met with Ms. D and MD at the hospital. Following an examination, MD was determined to be in good condition and released to go home with his mother. MD remained at home the next day, but on Thursday, November 29, 2012 attended school. OSSE has agreed to reimburse Ms. D for transportation to allow her to accompany MD to school as she has requested.

Conclusion

OSSE DOT followed procedures and conducted an investigation of the event. The investigation includes many facets such as care of the child, a review of events, the relevant documentation and interviews of individuals who were involved. Best practice policy and procedures currently in place adequately address this matter, but the procedures were not followed. OSSE has taken appropriate disciplinary action to terminate the bus driver and the attendant. Although this incident is a rare occurrence, we take each and every incident extremely seriously. It is unfortunate that even seasoned employees can make serious misjudgments. The driver had served DOT for 10 years, and the attendant had been in service for 6 years. OSSE DOT takes a zero based tolerance for any action that affects the health and well being of children in its care. We take these responsibilities seriously, and will continue to routinely provide mandatory training for drivers and attendants to ensure they remain alert to policies and procedures and the necessity for strict adherence to these protocols. Respectfully submitted,

Ryan Solchenberger, Director, Department of Transportation